

932

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No.

1003

Registrar's No.

3637

-63-013305

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No.

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

City Hosp. No. 1

Length of stay in lb

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

Missouri

c. CITY OR TOWN

St. Louis

d. STREET ADDRESS

2638 A Franklin Ave.

3. NAME OF DECEASED (Type or print)

Beattie A. Taylor Grant

4. DATE OF DEATH Month: 3 Day: 27 Year: 1963

5. SEX
Female

6. COLOR OR RACE
Colored

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

1889 73 yrs.

9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (City and state or country)
Missouri

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Mungo

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Leo Brinkley-2407 O'Fallon Apt. 303

18. CAUSE OF DEATH (Enter only one cause per item. If more than one, list in PART II. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to above - (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z).

IMMEDIATE CAUSE (a)

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year

Patient found dead March 27 About 730 AM

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 24 to March 27 and last saw her alive on March 27. Death occurred at 730 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

3-28-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

4/2/1963

23c. NAME OF CEMETERY OR CREMATORY

Washington Park Cemetery St. Louis (County) Mo.

24. FUNERAL DIRECTOR

ADDRESS

Ellis Funeral Home-2820 Stoddard St.

25. DATE RECD. BY LOCAL REG.

MAR 29 1963

26. REGISTRAR'S SIGNATURE

Leo Smith MD

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Fulton E. Pickett

Licensed Embalmer No. 4198

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.